

§ 412.424

42 CFR Ch. IV (10–1–13 Edition)

in § 412.424, and the facility-specific payment rate as specified in § 412.426.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as specified in subpart G of part 409 of this chapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient psychiatric facility, but not the cost of an approved medical education program as specified in § 413.75 through § 413.85 of this chapter.

(2) In addition to the Federal per diem payment amounts, inpatient psychiatric facilities receive payment for bad debts of Medicare beneficiaries, as specified in § 413.89 of this chapter.

[69 FR 66977, Nov. 15, 2004; 70 FR 19728, Apr. 1, 2005, as amended at 76 FR 26465, May 6, 2011]

§ 412.424 Methodology for calculating the Federal per diem payment amount.

(a) *Data sources.* (1) To calculate the Federal per diem base rate (as specified in paragraph (b) of this section for inpatient psychiatric facilities, as specified in paragraph (b) of this section, CMS uses the following data sources:

(2) The best Medicare data available to estimate the average inpatient operating and capital-related costs per day made as specified in part 413 of this chapter.

(i) Patient and facility cost report data capturing routine and ancillary costs.

(ii) An appropriate wage index to adjust for wage differences.

(iii) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by inpatient psychiatric facilities.

(b) *Determining the average per diem cost of inpatient psychiatric facilities for FY 2002.* CMS determines the average inpatient operating, ancillary, and capital-related per diem cost for which payment is made to each inpatient psychiatric facility, using the available data described in paragraph (a) of this section.

(c) *Determining the Federal per diem base rate for cost reporting periods beginning on or after January 1, 2005 through*

June 30, 2006—(1) *General.* Payment under the inpatient psychiatric facility prospective payment system is based on a standardized per diem payment referred to as the Federal per diem base rate. The Federal per diem base rate is the adjusted cost for 1 day of inpatient hospital services in an inpatient psychiatric facility in a base year as described in paragraph (b) of this section. The adjusted cost per day is adjusted in accordance with paragraphs (c)(2) through (c)(5) of this section.

(2) *Update of the average per diem cost.* CMS applies the increase factor described in paragraph (a)(2)(iii) of this section to the updated average per diem cost to the midpoint of the January 1, 2005 through June 30, 2006, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act.

(3) *Budget neutrality.* (i) CMS adjusts the updated average per diem cost so that the aggregate payments in the first 18 months (for January 1, 2005 through June 30, 2006) under the inpatient psychiatric facility prospective payment system are estimated to equal the amount that would have been made to the inpatient psychiatric facilities under part 413 of this chapter if the inpatient psychiatric facility prospective payment system described in this subpart were not implemented.

(ii) CMS evaluates the accuracy of the budget-neutrality adjustment within the first 5 years after implementation of the inpatient psychiatric facility prospective payment system. CMS may make a one-time prospective adjustment to the Federal per diem base rate to account for significant differences between the historical data on cost-based TEFRA payments (the basis of the budget-neutrality adjustment at the time of implementation) and estimates of TEFRA payments based on actual data from the first year of the prospective payment system.

(4) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of outlier payments described in paragraph (d)(3)(i) of this section.

(5) *Standardization.* CMS determines a reduction factor to reflect estimated increases in the Federal per diem base rate as defined in § 412.402 resulting from the facility-level and patient-

level adjustments described in paragraph (d) of this section.

(6) *Computation of the Federal per diem base rate.* The Federal per diem base rate is computed as follows:

(i) For cost reporting periods beginning on or after January 1, 2005 and on or before June 30, 2006, the Federal per diem base rate is computed in accordance with paragraph (c) of this section.

(ii) For inpatient psychiatric facilities beginning on or after July 1, 2006, the Federal per diem base rate will be the Federal per diem base rate for the previous year, updated by an increase factor described in paragraph (a)(2)(iii) of this section.

(d) *Determining the Federal per diem payment amount.* The Federal per diem payment amount is the product of the Federal per diem base rate established under paragraph (c) of this section, the facility-level adjustments applicable to the inpatient psychiatric facility, patient-level adjustments and other policy adjustments applicable to the case.

(1) *Facility-level adjustments—(i) Adjustment for wages.* CMS adjusts the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the inpatient psychiatric facility in an urban or rural area as defined in § 412.402.

(ii) *Rural location.* CMS adjusts the Federal per diem base rate for inpatient psychiatric facilities located in a rural area as defined in § 412.402.

(iii) *Teaching adjustment.* CMS adjusts the Federal per diem base rate by a factor to account for indirect teaching costs.

(A) An inpatient psychiatric facility's teaching adjustment is based on the ratio of the number of full-time equivalent residents training in the inpatient psychiatric facility divided by the facility's average daily census.

(B) Residents with less than full-time status and residents rotating through the inpatient psychiatric facility for less than a full year will be counted in proportion to the time they spend in the inpatient psychiatric facility.

(C) Except as described in paragraph (d)(1)(iii)(D) of this section, the actual number of current year full-time equivalent

residents used in calculating the teaching adjustment is limited to the number of full-time equivalent residents in the inpatient psychiatric facility's most recently filed cost report filed with its fiscal intermediary before November 15, 2004 (base year).

(D) If the inpatient psychiatric facility first begins training residents in a new approved graduate medical education program after November 15, 2004, the number of full-time equivalent residents determined under paragraph (d)(1)(iii)(C) of this section may be adjusted using the method described in § 413.79(e)(1)(i) and (ii) of this chapter.

(E) The teaching adjustment is made on a claim basis as an interim payment, and the final payment in full for the claim is made during the final settlement of the cost report.

(F) *Closure of an IPF.* (1) For cost reporting periods beginning on or after July 1, 2011, an IPF may receive a temporary adjustment to its FTE cap to reflect residents added because of another IPF's closure if the IPF meets the following criteria:

(i) The IPF is training additional residents from an IPF that closed on or after July 1, 2011.

(ii) No later than 60 days after the IPF begins to train the residents, the IPF submits a request to its Medicare contractor for a temporary adjustment to its cap, documents that the IPF is eligible for this temporary adjustment by identifying the residents who have come from the closed IPF and have caused the IPF to exceed its cap, and specifies the length of time the adjustment is needed.

(2) *Closure of an IPF's residency training program.* If an IPF that closes its residency training program on or after July 1, 2011, agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (d)(1)(iii)(F)(2)(ii) of this section, another IPF(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (d)(1)(iii)(F)(2)(i) of this section are met.

(i) *Receiving IPF(s).* For cost reporting periods beginning on or after July

1, 2011, an IPF may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another IPF's residency training program if the IPF is training additional residents from the residency training program of an IPF that closed a program; and if no later than 60 days after the IPF begins to train the residents, the IPF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another IPF's closed program and have caused the IPF to exceed its cap, specifies the length of time the adjustment is needed, and submits to its Medicare contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (d)(1)(iii)(F)(2)(ii) of this section.

(ii) *IPF that closed its program.* An IPF that agrees to train residents who have been displaced by the closure of another IPF's program may receive a temporary FTE cap adjustment only if the hospital with the closed program temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed. No later than 60 days after the residents who were in the closed program begin training at another hospital, the hospital with the closed program must submit to its Medicare contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IPF training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the IPFs to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(iv) *Inpatient psychiatric facilities located in Alaska and Hawaii.* CMS adjusts the non-labor portion of the Federal per diem base rate to reflect the

higher cost of living of inpatient psychiatric facilities located in Alaska and Hawaii.

(v) *Adjustment for IPF with qualifying emergency departments.* (A) CMS adjusts the Federal per diem base rate to account for the costs associated with maintaining a qualifying emergency department. A qualifying emergency department is staffed and equipped to furnish a comprehensive array of emergency services (medical and psychiatric) and meets the requirements of §§ 489.24(b) and 413.65 of this chapter.

(B) Where the inpatient psychiatric facility is part of an acute care hospital that has a qualifying emergency department as described in paragraph (d)(1)(v)(A) of this section and an individual patient is discharged to the inpatient psychiatric facility from that acute care hospital, CMS would not apply the emergency adjustment.

(vi) *Applicable percentage change for fiscal year 2014 payment determination and for subsequent years.* (A) In the case of an inpatient psychiatric facility that is paid under the prospective payment system in § 412.1(a)(2) that does not submit quality data to CMS, in the form and manner and at a time specified by CMS, the applicable annual update to a Federal standard rate is reduced by 2.0 percentage points.

(B) Any reduction in the applicable annual update to a Federal standard rate will apply only to the fiscal year involved and will not be taken into account in computing the annual payment update for a subsequent year.

(2) *Patient-level adjustments.* The inpatient psychiatric facility must identify a principal psychiatric diagnosis as specified in § 412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the diagnosis-related group assignment associated with the principal diagnosis, as specified by CMS.

(i) *Age.* CMS adjusts the Federal per diem base rate to account for patient age based on age groupings specified by CMS.

(ii) *Diagnosis-related group assignment.* The inpatient psychiatric facility must identify a principal diagnosis as specified in § 412.27(a) for each patient. CMS adjusts the Federal per diem base rate

by a factor to account for the CMS inpatient psychiatric facility prospective payment system recognized diagnosis-related group assignment associated with each patient's principal diagnosis.

(iii) [Reserved]

(iv) *Comorbidities*. CMS adjusts the Federal per diem base rate by a factor to account for certain comorbidities as specified by CMS.

(v) *Variable per diem adjustments*. CMS adjusts the Federal per diem base rate by factors as specified by CMS to account for the cost of each day of inpatient psychiatric care relative to the cost of the median length of stay.

(3) *Other adjustments*. (i) *Outlier payments*. CMS provides an outlier payment if an inpatient psychiatric facility's estimated total cost for a case exceeds a fixed dollar loss threshold amount for an inpatient psychiatric facility as defined in §412.402 plus the Federal payment amount for the case.

(A) The fixed dollar loss threshold amount is adjusted for the inpatient psychiatric facility's adjustments for wage area, teaching, rural locations, and cost of living adjustment for facilities located in Alaska and Hawaii.

(B) The outlier payment equals a percentage of the difference between the IPF's estimated cost for the case and the adjusted threshold amount specified by CMS for each day of the inpatient stay.

(C) For discharges occurring in cost reporting periods beginning on or after January 1, 2005, outlier payments are subject to the adjustments specified at §§412.84(i) and 412.84(m) of this part, except that national urban and rural median cost-to-charge ratios would be used instead of statewide average cost-to-charge ratios.

(ii) *Stop-loss payments*. CMS will provide additional payments during the transition period, specified in §412.426(a)(1) through (3), to an inpatient psychiatric facility to ensure that aggregate payments under the prospective payment system are at least 70 percent of the amount the inpatient psychiatric facility would have received under reasonable cost reimbursement had the prospective payment system not been implemented.

(iii) *Special payment provision for interrupted stays*. If a patient is dis-

charged from an inpatient psychiatric facility and is admitted to the same or another inpatient psychiatric facility within 3 consecutive calendar days following the discharge, the case is considered to be continuous for the purposes listed below. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of day 3.

(A) Determining the appropriate variable per diem adjustment, as specified in paragraph (d)(2)(v) of this section, applicable to the case.

(B) Determining whether the total cost for a case meets the criteria for outlier payments, as specified in paragraph (d)(3)(i)(C) of this section.

(iv) Payment for electroconvulsive therapy treatments. CMS provides an additional payment to reflect the cost of electroconvulsive therapy treatments received by a patient during an inpatient psychiatric facility stay in a manner specified by CMS.

[69 FR 66977, Nov. 15, 2004; 70 FR 16729, Apr. 1, 2005, as amended at 71 FR 27086, May 9, 2006; 76 FR 26465, May 6, 2011; 77 FR 53678, Aug. 31, 2012]

§412.426 Transition period.

(a) *Duration of transition period and composition of the blended transition payment*. Except as provided in paragraph (c) of this section, for cost reporting periods beginning on or after January 1, 2005 through December 31, 2007, an inpatient psychiatric facility receives a payment comprised of a blend of the estimated Federal per diem payment amount, as specified in §412.424(d) of this subpart and a facility-specific payment as specified under paragraph (b) of this section.

(1) For cost reporting periods beginning on or after January 1, 2005 and before January 1, 2006, payment is based on 75 percent of the facility-specific payment and 25 percent is based on the Federal per diem payment amount.

(2) For cost reporting periods beginning on or after January 1, 2006 and before January 1, 2007, payment is based on 50 percent of the facility-specific payment and 50 percent is based on the Federal per diem payment amount.